Application for Program Participation

Part 1: Child Information		
Last Name:	First/Middle	Preferred:
Birth Date:	☐ Male ☐ Female	Parental Status: ☐ One ☐ Two
Living Address:		
City:	State:	Zip:

Part2: Child Demographics	
Race (check all that apply): ☐ American Indian / Alaska Native ☐ Black/ African American ☐ Hawaiian / Pacific Islander ☐ Asian ☐ White ☐ Other:	**Language Information:** Primary Language:
	Secondary Language (if application):
Ethnicity:	Level of English Fluency: ☐ Fluent ☐ Proficient ☐ Moderate ☐ Poor ☐ None
Nationality:	

Part 3: Child Needs
Does your child have a disability (diagnosed by a doctor or specialist)? ☐ Yes ☐ No
If yes, what is the specific disability?
Does your child have an IEP or IFSP? ☐ Yes ☐ No
Do you have any concerns about your child in any of the following areas (check all that apply)*: ☐ Hearing ☐ Speech or Language *If you checked any category, ☐ Vision ☐ Physical Development please describe your concerns ☐ Underweight ☐ Behavioral Problems below: ☐ Overweight ☐ Emotional Problems ☐ Dental Issues ☐ Other Developments Concerns ☐ Allergies ☐ Asthma ☐ Other Medical concerns

Part 4: Parent / Guardian Information

Parent/Guardian Name 1:		DOB:
Living Address:		
City	State:	Zip:

Primary Phone Number:	Secondary Phone Number:
Head of household: ☐ Yes ☐ No	Teen Parent ☐ Yes ☐ No
Has Legal Custody: ☐ Yes ☐ No	Lives with Child: ☐ Yes ☐ No
Has chronic health issue or disability? ☐ Yes ☐ No If yes, please specify below and provide documentation with application.	Has diagnostic mental illness? ☐ Yes ☐ No If yes, please specify below and provide documentation with application.

Child's Relationship to Adult:

☐ Natural / Adopted / Stepchild
☐ Grandchild
☐ Niece / Nephew
☐ Foster Child
☐ Other:

Adult's English Proficiency:

☐ Fluent
☐ Proficient
☐ Moderate
☐ Poor
☐ None

If English is not adult's primary language, please specify the primary language: _____

Adult's Education Level:

☐ Less than High School
☐ GED
☐ High School Diploma
☐ Some College, no degree
☐ Associates Degree
☐ Bachelors Degree
☐ Masters or Doctorate Degree

Adult's Employment Status:

☐ Full Time (35+ hours/week)
☐ Part Time
☐ Unemployed
☐ Seasonally Employed
☐ Enrolled in School and Training Program
☐ Disabled
☐ Retired

Parent and Guardian Name 2:		DOB:
Living Address:		
City:	Status:	Zip:

Primary Phone Number:	Secondary Phone Number:
Head of Household: ☐ Yes ☐ No	Teen Parent: ☐ Yes ☐ No
Has Legal Custody: ☐ Yes ☐ No	Lives with Child: ☐ Yes ☐ No
Has chronic health issue or disability? ☐ Yes ☐ No If yes, please specify below and provide documentation with the application.	**Has diagnostic mental illness?** ☐ Yes ☐ No If yes, please specify below and provide documentation with the application.

Part 4: Parent / Guardian Information (Continued)

Child's Relationship to Adult:	**Adult's English Proficiency:**
☐ Natural / Adopted / Stepchild ☐ Grandchild ☐ Niece / Nephew ☐ Foster Child ☐ Other: _____	☐ Fluent ☐ Proficient ☐ Moderate ☐ Poor ☐ None If English is not adult's primary language, please specify the primary language: _____
Adult's Education Level:	**Adult's Employment Status:**
☐ Less than High School ☐ GED ☐ High School Diploma ☐ Some College, no degree ☐ Associates Degree ☐ Bachelors Degree ☐ Masters or Doctorate Degree	☐ Full Time (35+ hours/week) ☐ Part Time ☐ Unemployed ☐ Seasonally Employed ☐ Enrolled in School and/or Training Program ☐ Disabled ☐ Retired

Part 5: Additional Family Members

List all people who live with the family and are supported by the parent or guardian's income.

Name:	Relationship to Child:	DOB:
Name:	Relationship to Child:	DOB:
Name:	Relationship to Child:	DOB:
Name:	Relationship to Child:	DOB:
Name:	Relationship to Child:	DOB:
Name:	Relationship to Child:	DOB:

Total number of people who live in the household and are part of the child's family: _____

Part 6: Family Information

Are any of the child parents/guardians on military deployment?
☐ Yes ☐ No

Has the family immigrated from another country?
☐ Yes ☐ No

Has there been a death in the household in the last 6 months?
☐ Yes ☐ No

Are there any abuse issues in the home (ex. Domestic abuse, drug abuse, etc.) ☐
Yes ☐ No
If yes, please specify: _____

Has the family received services from DHS in the last 12 months?
☐ Yes ☐ No

Does any member of the family receive SSI benefits?
☐ Yes ☐ No

Does the family receive TANF (cash assistance)?
☐ Yes ☐ No
If yes, what is the case number?

Is the child currently receiving WIC?
☐ Yes ☐ No

Part 6: Family Information (Continued)

What services or assistance is the family receiving (check all that apply)?

☐ Child Care Subsidies
☐ Energy Assistance / LIHEAP
☐ Foster Care or Adoption Subsidies
☐ Health Services
☐ Mental Health Services
☐ Supplemental Nutrition Assistance Program (Food Stamps)
☐ Child Support or Alimony
☐ Public Housing Assistance
☐ Medical Assistance
☐ CHIP
☐ Unemployment Insurance

Are any of the child's parents or legal guardians currently incarcerated?

☐ Yes No ☐

Is your family currently dealing with any legal issues such as family court, divorce, probation/parole, custody issues, or restraining orders?

☐ Yes No ☐
If yes, please specify:

_____

_____

_____

_____

_____

_____

_____

_____

Part 7: Additional Information

Has your child been enrolled in Early Head Start?
☐ Yes No ☐
If yes, what program?

Has your child ever been enrolled in another Head Start program?
☐ Yes No ☐
If yes, what program?

Does your child have any siblings currently enrolled in a Head Start program?
☐ Yes No ☐

Has your child been enrolled in a childcare program?
☐ Yes No ☐
If yes, what program?

How did you hear about our program?

☐ Family or Friend
☐ Flyer or Advertisement
☐ Older child previously enrolled
☐ Knows a staff member
☐ Referral from professional agency

If referred by a professional program, please list:

Please sign here to verify you have provided complete and accurate information:

Name of Parent/Guardian:	
Signature of Parent/Guardian:	**Date:**

Office Use Only:	
Name of Family Services Staff:	
Signature of Family Services Staff:	**Date:**

Emergency Contact and Consent Form

Child's Name:_____

DOB:_____

Your child will not be released to anyone who is not listed as an Emergency Contact. You can add people to this list anytime, but **you cannot authorize a pick-up over the phone.** Please provide information for at least three people in addition to the parent(s)/guardian(s). Please notify the individuals listed that they are Emergency Contact and will be required to provide a photo ID when picking up your child.

Name	Relationship to Child:	Address:	Phone Number(s):	Speaks English?
	Parent/Guardian		Cell: Other:	☐ Yes ☐ No
	Parent/Guardian		Cell: Other:	☐ Yes ☐ No
			Cell: Other:	☐ Yes ☐ No
			Cell: Other:	☐ Yes ☐ No
			Cell: Other:	☐ Yes ☐ No

In the event of an emergency affecting your child, program staff will make every effort to contact you immediately. However, in certain circumstances, staff may need to take protective actions for your child before being able to contact you. We need your permission to do so. **Initial next to each item.**

Initials:

1. I permit to take emergency measures (ex, first aid, disaster evacuation) as considered necessary for the care and safety of my child while present at the center. _____
2. I permit my child to receive x-rays, examinations, anesthesia, and medical, surgical, or dental treatment under the supervision of a licensed doctor, dentist, or surgeon should an emergency arise and I cannot be contacted. _____
3. In the care of a medical emergency, I permit my child to be transported by ambulance to a medical facility or emergency resources. _____
4. If my child's center needs to be evacuated, I permit my child to be transported to the designated evacuation location. I understand that I will be notified at the earliest possible opportunity. _____
5. I understand that in some medical situations, the Director will need to contact emergency resources before the parent, child's physician, and/or other adults act on the parent's behalf. _____

Doctor's Name:	**Phone #:**	**Address:**
Dentist Name:	**Phone #:**	**Address:**
Name of insurance	**Type of insurance** **CHIP Medical Assistance Private**	**Policy Number:**

Parent/Guardian Signature:_____ **Date:**_____

Family Service Specialist Signature:_____ **Date:**_____

Reporting of Child Abuse and/or Neglect Policy

In accordance with state resolution, we are required to report incidents of suspected child abuse and/or neglect to the appropriate state and local authorities in accordance with the state law. All staff and the staff of all delegate agencies will preserve the confidentiality of all child abuse and/ or neglect records in accordance with applicable state or local laws. Failure to report child abuse and/or neglect could result in defunding of the program.

The Child Abuse and/or Neglect Policy has been read and explained to me, and I understand the above-stated information.

Parent/Guardian Signature:	**Date:**
Family Service Specialist Signature:	**Date:**

Consent for Services and Activities

Consent for Services

In order to provide high-quality services to your child and family, we need your consent for the following screenings and services. Please **initial** on each line if you are consenting to each service.

Initials:

1. I permit my child to participate in screenings, assessments, and observations required for program staff to understand their development and provide the best possible learning environment. _____

a. **Health Screenings:** hearing, vision, height, weight, blood iron, blood pressure, lead, dental _____

b. **Developmental Screenings:** to identify the child's stages of development _____

c. **Social-Emotional/Behavioral Screening:** to identify possible areas of mental health concern _____

d. **Classroom Observation:** to gain information about the child's participation in the classroom, _____

e. **Speech Screening:** to identify possible concerns regarding language development _____

f. **Ongoing Developmental Assessments:** to monitor child's progress in all areas _____

Consent for Activities

Please initial on each line if you consent to each activity.

Initials:

1. I permit for my child to participate in walking trips within a mile of the center, including to parks and/or playgrounds. _____

2. I permit my child to be photographed and/or videotaped while participating in program activities and for these photos and/or videos to be used in newsletters, displays, or other formats for education and/or program publicity. _____

Release of Information

Please initial on each line that you understand each statement and sign below.

As the parent/guardian of a child, I understand that: **Initials:**

1. We maintain a file on my child and family, containing all information necessary to provide high-quality services and to meet the requirements. _____

2. Staff may occasionally be asked to provide information about my child to certain official persons, including: local school personnel, health care personnel, welfare or other government officials. I understand that whenever possible, program staff will attempt to get my written permission but that this may not always be possible. _____

3. I understand that program staff need to share observations and information with each other in a respectful and confidential manner regarding my child's development, behavior, and participation in the program in order to help my child learn and grow. _____

4. I may review my child's file at any time. _____

Parent/Guardian Signature: _____ **Date:**_____

Family Service Specialist Signature: _____ **Date:**_____

Oral Health Form----Children

[redacted]

Child's name _____ Date of birth _____ Parent's/guardian's name _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

This practice is the child's dental home: ☐ Yes No ☐

Current Oral Health Status

Does the child have any teeth untreated decay? ☐ Yes (decay) ☐ No (decay free)
Does the child have any teeth previously treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No
Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

[redacted]

Diagnostic/Preventive Services

Examination:	☐ Yes	☐ No
Filling:	☐ Yes	☐ No
X-ray:	☐ Yes	☐ No
Crowns:	☐ Yes	☐ No
Risk Assessment:	☐ Yes	☐ No
Extractions:	☐ Yes	☐ No
Cleaning:	☐ Yes	☐ No
Emergency care:	☐ Yes	☐ No
Fluoride varnish:	☐ Yes	☐ No
Dental sealants:	☐ Yes	☐ No

(Please specify)

Counseling/Anticipatory guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____
(Please specify specialist)

Restorative/Emergency Care

Other:_____

[redacted]

All treatment Completed: ☐ Yes ☐ No Next recall date: _____ / _____ (month/year)
More appointments needed for treatment? ☐ Yes ☐ No
If yes: Approximate number of appointments needed: _____ Next appointment: Date: _____ Time: _____

[redacted]

Provider name (please print) _____ Phone Number _____ Fax Number _____

Practice Name _____ Address _____

Provider Signature _____ Date of service _____

Initial Health History

Child's Name: _____
DOB: _____
Center/Class: _____
Date: _____

Pregnancy and Birth History

Did the mother receive prenatal care during the entire pregnancy?
☐ Yes ☐ No
If no, please explain:

Were there any problems/concerns with the mother or child during pregnancy?
☐ Yes ☐ No
If no, please explain:

Was the mother or child required to stay in the hospital longer than usual due to a medical concern?
☐ Yes ☐ No
If no, please explain:

Was the child born more than 3 weeks early or late?
☐ Yes ☐ No
If no, please explain:

*Please note, all medical information is confidential.

During the pregnancy, did the mother use:

☐ Cigarettes
☐ Drugs
☐ Alcohol
☐ Prescription Medication(s)

Birth Weight:
_____ lbs. / _____oz.

Type of delivery:

☐ Vaginal ☐ C-Section

Child Medical History

Does the child have a diagnosed medical condition?
☐ Yes ☐ No
If no, please explain:

Does the child have a diagnosed disability?
☐ Yes ☐ No
If no, please explain:

Does the child have a special diet or nutritional needs related to a medical condition or disability?
☐ Yes ☐ No
If no, please explain:

Does/has the child had issues with:
(check all that apply)

☐ Traumas/Injuries
☐ Hospitalizations/Surgeries
☐ Infections (Ear, Throat, Kidneys, etc.)
☐ Stomach Pain, Vomiting, Diarrhea
☐ Heart/Blood Vessel Disease
☐ Liver Disease
☐ Sickle Cell disease
☐ Rheumatic Fever
☐ Pneumonia/RSV
☐ Visual Problems
☐ Hearing Problems
☐ Lead Levels
☐ G6PD
☐ Chicken Pox
☐ Diabetes
☐ Seizures
☐ Asthma
☐ Eczema
☐ Epilepsy
☐ Anemia
☐ Other: _____

Child Medical History, continued

Medications:

Does the child take any medications?

☐ Yes ☐ No

If yes, please list (indicate if medication is taken daily or as needed):

Name: _____

Dosage: _____ **Time:** _____

Name: _____

Dosage: _____ **Time:** _____

Name: _____

Dosage: _____ **Time:** _____

Will any of these medications need to be administered during program hours?

☐ Yes ☐ No If yes, which medication(s)?

_____

_____

_____

Allergies:

Does the child have any allergies?

☐ Yes ☐ No

If yes, please specify:

_____

_____

_____

_____

☐ Food(s)
☐ Drugs or Medications
☐ Environment (e.g., bee stings).

Does the child require an EpiPen?

☐ Yes ☐ No

Does your child have any additional health issues?

☐ Yes ☐ No

If yes, please explain:

Does your child wear diapers or pull-ups?

☐ Yes ☐ No

If yes, please explain any toilet training needs:

Please sign below to verify you have provided complete and accurate information:	
Parent/Guardian Signature:	**Date:**
Family Service Staff Signature:	**Date:**

Nutrition Questionnaire

Child's Name:	**Parent Guardian Name:**
DOB:	**Center/Class:**

What did your child eat in the last 24 hours? Please be as specific as possible, and include all snacks and beverages. List main ingredients in prepared dishes.

Breakfast:
Lunch:
Dinner:
Snacks (throughout the day):

Are you concerned about what your child eats? ☐ Yes ☐ No If yes, please explain:	Has your family set meal and snack times together? ☐ Yes ☐ No
Do you have any concerns about the weight of your child? ☐ Yes ☐ No If yes, please explain:	How often per week does your family eat fast food? ☐ Less than 1 ☐ 1-2 ☐ 3-4 ☐ More than 5
Does your child have any food allergies? ☐ Yes ☐ No If yes, please explain:	Do you need assistance with getting food for your family? ☐ Yes ☐ No
Does your child chew on or eat things that are not food? ☐ Yes ☐ No If yes, please explain:	Are there any food restrictions for religious reasons? ☐ Yes ☐ No If yes, what is excluded?
Does your child brush their teeth daily? ☐ Yes ☐ No If yes, please explain:	How many hours per day does your child watch TV and/or play video games? Hours:
Does your child take vitamins, iron, or fluoride supplements? ☐ Yes ☐ No If yes, what does your child take?	How many hours per day does your child play actively (i.e., running, biking, skipping, swimming, dancing, etc.)? Hours:
Is your child enrolled in WIC? ☐ Yes ☐ No	

Parent/Guardian Signature:	**Date:**
Family Service Specialist Signature:	**Date:**

Individual Health Plan

Section 1: To be completed by Parent/Guardian	
Child's Name:	**DOB:**
Address:	**Gender:**
Parent/Guardian Name:	**Center:**
Home Phone:	**Class:**
Other Phone:	**Family Services Specialist:**

Section 2: To be completed by Healthcare Provider	
Diagnosis: Describe the diagnosis, medical condition, food allergies/intolerances, special diet, developmental issues, and/or particular needs of the child.	**Symptoms:** What signs/symptoms should program staff be aware of regarding this child's diagnosis?
Recommendations: List all recommendations for care during center hours related to diet, feeding, mobility, medications, toileting, etc.	**Emergency Care:** List any procedures for staff to follow in the event of an emergency or possible reaction or exposure to allergens.
Please indicate any other comments about the child's diagnosis and/or condition:	

Section 2: To be completed by Healthcare Provider

Please list each medication the child is prescribed:

Medication Name:	Dosage:	Frequency:	Reason for Medication:	Possible Side Effects:	Route of Administration:
1.					
2.					
3.					
4.					

Is injectable medication required as part of the child's course of treatment or in response to respiratory distress or severe allergic reactions?

☐ Yes ☐ No

If yes, please complete the injectable medications table below.

Medication Name:	Dosage:	Frequency:	Reason for Medication:	Possible Side Effects:	Injection Site:
1.					
2.					
3.					

Please indicate any other information program staff need to know about this child's health status:

Healthcare Provider's Signature:

Name:	**Address:**
Signature:	
Date:	**Telephone:**

Parent/Guardian Signature:

I understand that by signing this, I am consenting to the administration of medication by PHSP staff as instructed by my child's health care provider.

Family Service Specialist Signature:	**Date:**

Family Partnership Agreement

Child's Name:_____ **DOB:**_____

What makes you proud about your family?	What activities does your family like to do together?
What are some challenges your family is dealing with right now?	What are some goals that you have for your family?

Goal-Setting

Goal:

Target Date:

Why is this goal important to you?

Action to be Taken:	By Whom:	Target Date:	Progress Update:	Date Completed:
			Follow-up 1: Follow-up 2:	
			Follow-up 1: Follow-up 2:	
			Follow-up 1: Follow-up 2:	
			Follow-up 1: Follow-up 2:	
			Follow-up 1: Follow-up 2:	

Parent/Guardian Signature:_____ **Date:**_____

Family Service Specialist Signature:_____ **Date:**_____

Family Strengths and Needs Assessment

Child's Name:	**DOB:**
Center/Class:	**Date:**

We need to know about your family's strengths in order to best include you in our programming and utilize your specific skills. We ask you to share information about your family's needs to provide high-quality services and support for you and each member of your family. Thank you for sharing this information with the program staff.

Please identify three family strengths:

1. _____

_____

2. _____

_____

3. _____

_____

Tell us opportunities you are seeking:

Housing Resources:	**Adult Education:**	**Employment:**
☐ Finding permanent housing ☐ Rental assistance programs ☐ Buying a home ☐ Tenant rights ☐ Budget and finance information	☐ Obtaining a GED ☐ Obtaining a high school diploma ☐ College prep ☐ Obtaining a college degree ☐ Financial Aid ☐ English classes	☐ Employment opportunities ☐ Job Fairs ☐ Job trainings ☐ Resume writing ☐ Career options
Parenting Information:	**Self-Care:**	**Volunteering:**
☐ Parenting Skills ☐ Co-Parenting ☐ Resources for guardians ☐ Understanding child development ☐ Kindergarten transition	☐ Physical health needs ☐ Mental health needs ☐ Disability rights ☐ Family and child safety ☐ Food and nutrition needs	☐ Storytelling ☐ Preparing materials ☐ Classroom activities

Program Decision-Making Opportunities:

All parents are invited to attend the monthly **Parent Center Committee** Meetings to learn about upcoming center activities and share feedback about the program. If elected by the Parent Center Committee, parents can serve on the program **Policy Council**, a group that makes decisions for the program. Are you interested in running for Policy Council? ☐ Yes ☐ No

Signature of Parent/Guardian:	**Date:**
Signature of Family Service Staff:	**Date:**